Sec. 1503. The department shall provide a copy of the federally approved Michigan first healthcare plan or similar proposal to the house of representatives and senate appropriations subcommittees on community health, the house and senate fiscal agencies, and the state budget director at least 90 days before implementing any portion of the Michigan first healthcare plan or other similar proposal.

MEDICAL SERVICES

Sec. 1601. The cost of remedial services incurred by residents of licensed adult foster care homes and licensed homes for the aged shall be used in determining financial eligibility for the medically needy. Remedial services include basic self-care and rehabilitation training for a resident.

Sec. 1602. Medical services shall be provided to elderly and disabled persons with incomes less than or equal to 100% of the official poverty level, pursuant to the state's option to elect such coverage set out at section 1902(a)(10)(A)(*ii*) and (m) of title **XIX,** 42 USC 1396a.

Sec. 1603. (1) The department may establish a program for persons to purchase medical coverage at a rate determined by the department.

(2) The department may receive and expend premiums for the buy-in of medical coverage in addition to the amounts appropriated in part 1.

(3) The premiums described in this section shall be classified as private funds

Sec. 1604. If an applicant for Medicaid coverage **is** found to be eligible, the department shall provide payment for all of the Medicaid covered and appropriately authorized services that have been provided to that applicant since the first day of the month in which the applicant filed and the department of human services received the application for Medicaid coverage. Receipt of the application by a local department of human services office is considered the date the application **is** received. If an application is submitted on the last day of the month and that day falls on a weekend or a holiday and the application is received by the local department of human services office on the first business day following the end of the month, then receipt of the application is considered to have been on the last day of the previous month. As used in this section, "completed application" means an application complete on its face and signed by the applicant regardless of whether the medical documentation required to make an eligibility determination is included.

Sec. 1605. (1) The protected income level for Medicaid coverage determined pursuant to section 106(1)(b)(*iii*) of the social welfare act, 1939 **PA** 280, MCL 400.106, shall be 100% of the related public assistance standard.

(2) The department shall notify the senate and house of representatives appropriations subcommittees on community health and the state budget director of any proposed revisions to the protected income level for Medicaid coverage related to the public assistance standard 90 days prior to implementation.

Sec. 1606. For the purpose of guardian and conservator charges, the department of community health may deduct up to $45.00 per month as an allowable expense against a recipient's income when determining medical services eligibility and patient pay amounts.

Sec. 1607. (1) An applicant for Medicaid, whose qualifying condition is pregnancy, shall immediately be presumed to be eligible for Medicaid coverage unless the preponderance of evidence in her application indicates otherwise. The applicant who is qualified as described in this subsection shall be allowed to select or remain with the Medicaid participating obstetrician of her choice.

(2) An applicant qualified as described in subsection (1) shall be given a letter of authorization to receive Medicaid covered services related to her pregnancy. All qualifying applicants shall be entitled to receive all medically necessary obstetrical and prenatal care without preauthorization from a health plan. All claims submitted for payment for obstetrical and prenatal care shall be paid at the Medicaid fee-for-service rate in the event a contract does not exist between the Medicaid participating obstetrical or prenatal care provider and the managed care plan. The applicant shall receive a listing of Medicaid physicians and managed care plans in the immediate vicinity of the applicant's residence.

(3) In the event that an applicant, presumed to be eligible pursuant to subsection (1), **is** subsequently found to be ineligible, a Medicaid physician or managed care plan that has been providing pregnancy services to an applicant under this section **is** entitled to reimbursement for those services until such time as they are notified by the department that the applicant was found to be ineligible for Medicaid.

(4) If the preponderance of evidence in an application indicates that the applicant is not eligible for Medicaid, the department shall refer that applicant to the nearest public health clinic or similar entity as a potential source for receiving pregnancy-related services.

(5) The department shall develop an enrollment process for pregnant women covered under this section that facilitates the selection of a managed care plan at the time of application.

Sec. 1610. The department of community health shall provide an administrative procedure for the review of cost report grievances by medical services providers with regard to reimbursement under the medical services program. Settlements of properly submitted cost reports shall be paid not later than 9 months from receipt of the final report.

Sec. 1611. (1) For care provided to medical services recipients with other third-party sources of payment, medical services reimbursement shall not exceed, in combination with such other resources, including Medicare, those amounts established for medical services-only patients. The medical services payment rate shall be accepted as payment in full. Other than an approved medical services copayment, no portion of a provider's charge shall be billed to the recipient or any person acting on behalf of the recipient. Nothing in this section shall be considered to affect the level of payment from a third-party source other than the medical services program. The department shall require a nonenrolled provider to accept medical services payments as payment in full.

(2) Notwithstanding subsection (1), medical services reimbursement for hospital services provided to dual Medicare/ medical services recipients with Medicare part B coverage only shall equal, when combined with payments for Medicare and other third-party resources, if any, those amounts established for medical services-only patients, including capital payments.

Sec. 1615. Unless prohibited by federal or state law or regulation, the department shall require enrolled Medicaid providers to submit their billings for services electronically.

Sec. 1620. (1) For fee-for-service recipients who do not reside in nursing homes, the pharmaceutical dispensing fee shall be $2.50 or the pharmacy's usual or customaly cash charge, whichever **is less.** For nursing home residents, the pharmaceutical dispensing fee shall be $2.75 or the pharmacy's usual or customaly cash charge, whichever **is** less.

(2) The department shall require a prescription copayment for Medicaid recipients of $1.00 for a generic drug and $3.00 for a brand-name drug, except as prohibited by federal or state law or regulation.

(3) For fee-for-service recipients, an optional mail-order pharmacy program shall be available.

Sec. 1621. (1) The department may implement prospective drug utilization review and disease management systems. The prospective drug utilization review and disease management systems authorized by this subsection shall have physician oversight, shall focus on patient, physician, and pharmacist education, and shall be developed in

consultation with the national pharmaceutical council, Michigan state medical society, Michigan association of osteopathic physicians, Michigan pharmacists association, Michigan health and hospital association, and Michigan nurses' association.

(2) This section does not authorize or allow therapeutic substitution

Sec. 1621a. (1) The department, in conjunction with pharmaceutical manufacturers or their agents, may establish pilot projects to test the efficacy of disease management and health management programs.

(2) The department may negotiate a plan that uses the savings resulting from the services rendered from these programs, in lieu of requiring a supplemental rebate for the inclusion of those participating parties' products on the department's preferred drug list.

Sec. 1623. (1) The department shall continue the Medicaid policy that allows for the dispensing of a 100-day supply for maintenance drugs.

(2) The department shall notify all HMOs, physicians, pharmacies, and other medical providers that are enrolled in the Medicaid program that Medicaid policy allows for the dispensing of a 100-day supply for maintenance drugs.

(3) The notice in subsection **(2)** shall also clarify that a pharmacy shall fill a prescription written for maintenance drugs in the quantity specified by the physician, hut not more than the maximum allowed under Medicaid, unless subsequent consultation with the prescribing physician indicates otherwise.

Sec. 1625. The department shall continue its practice ofplacing all atypical antipsychotic medications on the Medicaid preferred drug list.

Sec. 1627. (1) The department shall use procedures and rebates amounts specified under section 1927 of title XIX. 42 USC 1396r-8, to secure quarterly rebates from pharmaceutical manufacturers for outpatient drugs dispensed to participants in the MIChild program, maternal outpatient medical services program, children's special health care services, and adult benefit waiver program.

(2) For products distributed by pharmaceutical manufacturers not providing quarterly rebates as listed in subsection (1), the department may require preauthorization.

Sec. 1628. (1) The department shall convene by April 2007 a committee to study the implementation of psychotropic pharmacy administration under Medicare part D for individuals dually enrolled in the Medicare and Medicaid programs, This committee shall study and evaluate the effectiveness of mental health consumer enrollment and medication access through the Medicare part D procedures for pharmaceutical management for dual eligibles.

(2) The committee shall include a representative from each of the following organizations: the medical services administration, the office of services to the aging, the department's mental health and substance abuse services division, mental health association of Michigan, national alliance for the mentally ill of Michigan, Michigan psychiatric society, Michigan association of community mental health boards, Michigan pharmacists association, Michigan protection and advocacy service, international association of psychosocial rehabilitation services, and the pharmaceutical industry. The committee shall elect a chairperson who is not employed by state government.

(3) The committee shall produce a report by September 30,2007 to the senate and house of representatives appropriations subcommittees on community health and the senate and house fiscal agencies.

Sec. 1629. The department shall utilize maximum allowable cost pricing for generic drugs that is based on wholesaler pricing to providers that is available from at least 2 wholesalers who deliver in the state of Michigan.

Sec. 1630. (1) Medicaid coverage for podiatric services, adult dental services, and chiropractic services shall continue at not less than the level in effect on October 1, 2002, except that reasonable utilization limitations may be adopted in order to prevent excess utilization. The department shall not impose utilization restrictions on chiropractic services unless a recipient has exceeded 18 office visits within 1 year.

(2) The department may implement the bulk purchase of hearing aids, impose limitations on binaural hearing aid benefits, and limit the replacement of hearing aids to once every 3 years.

Sec. 1631. (1) The department shall require copayments on dental, podiatric, chiropractic, vision, and hearing aid services provided to Medicaid recipients, except **as** prohibited by federal or state law or regulation.

(2) Except as otherwise prohibited by federal or state law or regulations, the department shall require Medicaid recipients to pay the following copayments:

(a) Two dollars for a physician office visit

(b) Six dollars for a hospital emergency room visit.

(c) Fifty dollars for the first day of an inpatient hospital stay.

(d) One dollar for an outpatient hospital visit

Sec. 1633. From the funds appropriated in part 1 for dental services, the department shall expand the healthy kids dental program statewide if funds become available specifically for expansion of the program.

Sec. 1634. From the funds appropriated in part 1 for ambulance services, the department shall continue the **5%** increase in payment rates for ambulance services implemented in fiscal year 2000-2001 and continue the ground mileage reimbursement rate per statute mile at **$4.25.**

Sec. 1635. From the funds appropriated in part 1 for physician services and health plan services, the department shall continue the increase in Medicaid reimbursement rates for obstetrical services implemented in fiscal year 2005-2006.

Sec. 1636. (1) From the funds appropriated in part 1 for physician services and health plan services, $16,623,600.00, of which $7,251,200.00 is general fund/general purpose funds, shall be allocated to increase Medicaid reimbursement rates for physician well child procedure codes and primary care procedure codes. The increased reimbursement rates in this section shall be implemented October 1, 2006 and shall not exceed the comparable Medicare payment rate for the same services.

(2) By October 1,2006, the department shall provide a report to the house of representatives and senate appropriations subcommittees on community health and the house and senate fiscal agencies that identifies the specific procedure codes affected by this provision **as** well **as** the amount and percentage increase provided for each procedure code.

Sec. 1637. (1) **All** adult Medicaid recipients shall be offered the opportunity to sign a Medicaid personal responsibility agreement.

(2) The personal responsibility agreement shall include at minimum the following provisions:

(a) That the recipient shall not smoke.

(b) That the recipient shall attend all scheduled medical appointments.

(c) That the recipient shall exercise regularly

(d) That if the recipient has children, those children shall be up to date on their immunizations

(e) That the recipient shall abstain from abusing controlled substances and narcotics

Sec. 1641. An institutional provider that is required to submit a cost report under the medical services program shall submit cost reports completed in full within 5 months after the end of its fiscal year.

Sec. 1643. Of the funds appropriated in part 1 for graduate medical education in the hospital services and therapy line-item appropriation, not less than $10,359,000.00 shall be allocated for the psychiatric residency training program that establishes and maintains collaborative relations with the schools of medicine at Michigan State University and Wayne State University if the necessary allowable Medicaid matching funds are provided by the universities.

Sec. 1647. From the funds appropriated in part 1 for medical services, the department shall allocate for graduate medical education not less than the level of rates and payments in effect on April 1,2005.

Sec. 1648. The department shall maintain an automated toll-free phone line to enable medical providers to verify the eligibility status of Medicaid recipients. There shall be no charge to providers for the use of the toll-free phone line.

Sec. 1649. From the funds appropriated in part 1 for medical services, the department shall continue breast and cervical cancer treatment coverage for women up to 250% of the federal poverty level, who are under age 65, and who are not otherwise covered by insurance. This coverage shall be provided to women who have been screened through the centers for disease control breast and cervical cancer early detection program, and are found to have breast or cervical cancer, pursuant to the breast and cervical cancer prevention and treatment act of 2000, Public Law 106-354, 114 Stat.1381.

Sec. 1650. (1) The department may require medical services recipients residing in counties offering managed care options to choose the particular managed care plan in which they wish to be enrolled. Persons not expressing a preference may be assigned **to** a managed care provider.

(2) Persons to be assigned a managed care provider shall be informed in writing of the criteria **for** exceptions to capitated managed care enrollment, their right **to** change HMOs for any reason within the initial 90 days of enrollment, the toll-free telephone number for problems and complaints, and information regarding grievance and appeals rights.

(3) The criteria for medical exceptions to HMO enrollment shall be based on submitted documentation that indicates a recipient has a serious medical condition, and is undergoing active treatment for that condition with a physician who does not participate in 1 of the HMOs. If the person meets the criteria established by this subsection, the department shall grant an exception to mandatoty enrollment at least through the current prescribed course of treatment, subject to periodic review of continued eligibility.

Sec. 1651. (1) Medical services patients who are enrolled in HMOs have the choice to elect hospice services **or** other services for the terminally ill that are offered by the HMOs. If the patient elects hospice services, those services shall be provided in accordance with part 214 of the public health code, 1978 PA 368, MCL 333.21401 **to** 333.21420.

(2) The department shall not amend the medical services hospice manual in a manner that would allow hospice services to be provided without making available all comprehensive hospice services described in 42 CFR part 418.

Sec. 1653. Implementation and contracting for managed care by the department through HMOs shall be subject to the following conditions:

(a) Continuity of care **is** assured by allowing enrollees to continue receiving required medically necessary services from their current providers for a period not to exceed 1 year if enrollees meet the managed care medical exception criteria.

(b) The department shall require contracted HMOs to submit data determined necessary for evaluation on a timely basis.

(c) Mandatory enrollment of Medicaid beneficiaries living in counties defined as rural by the federal government, which is any nonnrban standard metropolitan statistical area, is allowed if there **is** only 1 HMO serving the Medicaid population, as long as each Medicaid beneficiary **is** assured of having a choice of at least **2** physicians by the HMO.

(d) Enrollment of recipients of children's special health care services in HMOs shall be voluntary during the fiscal year.

(e) The department shall develop a case adjustment to its rate methodology that considers the costs of persons with HIV/AIDS, end stage renal disease, organ transplants, and other high-cost diseases or conditions and shall implement the case adjustment when it is proven to be actuarially and fiscally sound. Implementation of the case adjustment must be budget neutral.

Sec. 1654. Medicaid HMOs shall provide for reimbursement of HMO covered services delivered other than through the HMOs providers if medically necessary and approved by the HMO, immediately required, and that could not be reasonably obtained through the HMOs providers on a timely basis. Such services shall be considered approved if the HMO does not respond to a request for authorization within 24 hours of the request. Reimbursement shall not exceed the Medicaid fee-for-service payment for those services.

Sec. 1655. (1) The department may require a 12-month lock-in to the HMO selected by the recipient during the initial and subsequent open enrollment periods, but allow for good cause exceptions during the lock-in period.

(2) Medicaid recipients shall be allowed to change HMOs for any reason within the initial 90 days of enrollment

Sec. 1656. (1) The department shall provide an expedited complaint review procedure for Medicaid eligible persons enrolled in HMOs for situations in which failure to receive any health care service would result in significant harm to the enrollee.

(2) The department shall provide for a toll-free telephone number for Medicaid recipients enrolled in managed care *to* assist with resolving problems and complaints. If warranted, the department shall immediately disenroll persons from managed care and approve fee-for-service coverage.

(3) Annual reports summarizing the problems and complaints reported and their resolution shall be provided to the house of representatives and senate appropriations subcommittees on community health, the house and senate fiscal agencies, and the state budget office.

Sec. 1657. (1) Reimbursement for medical services to screen and stabilize a Medicaid recipient, including stabilization of a psychiatric crisis, in a hospital emergency room shall not be made contingent on obtaining prior authorization from the recipient's HMO. If the recipient is discharged from the emergency room, the hospital shall notify the recipient's HMO within 24 hours of the diagnosis and treatment received.

(2) If the treating hospital determines that the recipient will require further medical service or hospitalization beyond the point of stabilization, that hospital must receive authorization from the recipient's HMO prior to admitting the recipient.

(3) Subsections (1) and (2) shall not be construed as a requirement to alter an existing agreement between an HMO and their contracting hospitals nor as a requirement that an HMO must reimburse for services that are not considered to be medically necessary.

(4) Prior to contracting with an HMO for managed care services that did not have a contract with the department before October 1, 2002, the department shall receive assurances from the office of financial and insurance services that the HMO meets the net worth and financial solvency requirements contained in chapter 35 of the insurance code of 1956,1956 PA 218, MCL 500.3501 to 500.3580.

Sec. 1658.(1) HMOs shall have contracts with hospitals within a reasonable distance from their enrollees. If a hospital does not contract with the HMO in its service area, that hospital shall enter into a hospital access agreement as specified in the MSA bulletin Hospital 01-19.

(2) A hospital access agreement specified in subsection (1) shall be considered an affiliated provider contract pursuant to the requirements contained in chapter 35 of the insurance code of 1956, 1956 PA 218, MCL 500.3501 to 500.3580.

Sec. 1659. The following sections of this act are the only ones that shall apply to the following Medicaid managed care programs, including the comprehensive plan, children's special health care services plan, MIChoice long-term care plan, and the mental health, substance abuse, and developmentally disabled services program: 401,402,404, 41 1,414,418,424,428,456, 1650, 1651, 1653,1654, 1655, 1656, 1657, 1658, 1660,1661, 1662,1666, 1699,1711, 1749, 1752, 1753, and 1766.

Sec. 1660. (1) The department shall assure that all Medicaid children have timely access to EPSDT services as required by federal law. Medicaid HMOs shall provide EPSDT services to their child members in accordance with Medicaid EPSDT policy.

(2) The primary responsibility of assuring a child's hearing and vision screening **is** with the child's primary care provider. The primary care provider shall provide age-appropriate screening or arrange for these tests through referrals to local health departments. Local health departments shall provide preschool hearing and vision screening services and accept referrals for these tests from physicians or from Head Start programs in order to assure all preschool children have appropriate access to hearing and vision screening. Local health departments shall be reimbursed for the cost of providing these tests for Medicaid eligible children by the Medicaid program.

(3) The department shall require Medicaid HMOs to provide EPSDT utilization data through the encounter data system, and health employer data and information set well child health measures in accordance with the National Committee on Quality Assurance prescribed methodology.

(4) The department shall require HMOs to be responsible for well child visits and maternal and infant support services as described in Medicaid policy. These responsibilities shall be specified in the information distributed by the HMOs to their members.

(5) The department shall provide, on an annual basis, budget neutral incentives to Medicaid HMOs and local health departments to improve performance on measures related to the care of children and pregnant women.

Sec. 1661. (1) The department shall assure that all Medicaid eligible children and pregnant women have timely access to MSS/ISS services. Medicaid HMOs shall assure that maternal support service screening is available to their pregnant members and that those women found to meet the maternal support service high-risk criteria are

offered maternal support services. Local health departments shall assure that maternal support service screening is available fur Medicaid pregnant women not enrolled in an HMO and that those women found to meet the maternal support service high-risk criteria are offered maternal support services or are referred to **a** certified maternal support service provider.

(2) The department shall prohibit HMOs from requiring prior authorization of their contracted providers for any EPSDT screening and diagnosis service, for any MSS/ISS screening referral, or for **up** to 3 MSS/ISS service visits.

(3) The *department* shall assure the coordination of MSS/ISS services with the WIC program, state-supported substance abuse, smoking prevention, and violence prevention programs, the department of human services, and any other state or local program with a focus on preventing adverse birth outcomes and child abuse and neglect.

Sec. 1662. (1) The department shall assure that an external quality review of each contracting HMO is performed that results in an analysis and evaluation of aggregated information on quality, timeliness, and access to health care services that the HMO or its contractors furnish to Medicaid beneficiaries.

(2) The department shall provide **a** copy of the analysis of the Medicaid HMO annual audited health employer data and information set reports and the annual external quality review report to the senate and house of representatives appropriations subcommittees on community health, the senate and house fiscal agencies, and the state budget director, within 30 days of the department's receipt of the final reports from the contractors.

(3) The department shall work with the Michigan association of health plans and the Michigan association for local public health to improve service delivery and coordination in the MSS/ISS and EPSDT programs.

(4) The department shall assure that training and technical assistance are available for EPSDT and MSS/ISS for Medicaid health plans, local health departments, and MSS/ISS contractors.

Sec. 1666. To increase timely repayment of the maternity case rate to health plans and reduce the need to recover revenue from hospitals, the department shall implement system changes to assure that children who are born to mothers who are Medicaid eligible and enrolled in health plans are within 30 days after birth included in the Medicaid eligibility file and enrolled in the same health plan as the mother or any other health plan designated by the mother.

Sec. 1670. (1) The appropriation in part 1 for the MIChild program is to be used to provide comprehensive health care to **all** children under age 19 who reside in families with income at or below 200% of the federal poverty level, who are uninsured and have not had coverage by other comprehensive health insurance within ***6*** months of making application for MIChild benefits, and who are residents of this state. The department shall develop detailed eligibility criteria through the medical services administration public concurrence process, consistent with the provisions of this act. Health care coverage for children in families below 150% of the federal poverty level shall be provided through expanded eligibility under the state's Medicaid program. Health coverage for children in families between 150% and 200% of the federal poverty level shall be provided through **a** state-based private health care program.

(2) The department may provide up to 1 year of continuous eligibility to children eligible for the MIChild program unless the family fails to pay the monthly premium, **a** child reaches age 19, **or** the status of the children's family changes and its members no longer meet the eligibility criteria as specified in the federally approved MIChild state plan.

(3) Children whose category of eligibility changes between the Medicaid and MIChild programs shall he assured of keeping their current health care providers through the current prescribed course of treatment for up to I year, subject to periodic reviews by the department if the beneficiary has **a** serious medical condition and is undergoing active treatment for that condition.

(4) To he eligible for the MlChild program, a child must he residing in a family with an adjusted gross income of less than or equal to 200% ofthe federal poverty level. The department's verification policy shall he used to determine eligibility.

(5) The department shall enter into a contract to obtain MlChild services from any HMO, dental care corporation, or any other entity that offers to provide the managed health care benefits for MlChild services at the MIChild capitated rate. **As** used in this subsection:

(a) "Dental care corporation", "health care corporation", "insurer", and "prudent purchaser agreement" mean those terms as defined in section 2 ofthe prudent purchaser act, 1984 **PA** 233, MCL 550.52.

(b) "Entity" means a health care corporation or insurer operating in accordance with a prudent purchaser agreement.

(6) The department may enter into contracts to obtain certain MlChild services from community mental health service programs.

(7) The department may make payments on behalf of children enrolled in the MlChild program from the line-item appropriation associated with the program as described in the MlChild state plan approved by the United States department of health and human services, or from other medical services line-item appropriations providing for specific health care services.

Sec. 1671. From the funds appropriated in part 1, the department shall continue a comprehensive approach to the marketing and outreach of the MIChild program. The marketing and outreach required under this section shall he coordinated with current outreach, information dissemination, and marketing efforts and activities conducted by the department.

Sec. **1673.** (1) The department may establish premiums for MlChild eligible persons in families with income above 150% of the federal poverty level. The monthly premiums shall not he less than $1 0.00 or exceed **$1** 5.00 for a family.

(2) The department shall not require copayments under the MlChild program.

Sec. **1677.** The MlChild program shall provide all benefits available under the state employee insurance plan that are delivered through contracted providers and consistent with federal law, including, but not limited to, the following medically necessary services:

(a) Inpatient mental health services, other than substance abuse treatment services, including services furnished in a state-operated mental hospital and residential or other 24-hour therapeutically planned structured services.

(h) Outpatient mental health services, other than substance abuse services, including services furnished in a state-operated mental hospital and community-based services.

(c) Durable medical equipment and prosthetic and orthotic devices.

(d) Dental services as outlined in the approved MlChild state plan.

(e) Substance abuse treatment services that may include inpatient, outpatient, and residential substance abuse treatment services.

(9 Care management services for mental health diagnoses.

(g) Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.

(h) Emergency ambulance services

Sec. 1680. (1) Payment increases for enhanced wages and new or enhanced employee benefits provided in previous years through the Medicaid nursing home wage pass-through program shall be continued in fiscal year 2006-2007.

(2) The department shall not implement any increase or decrease in the Medicaid nursing home wage pass-through program in fiscal year 2005-2006.

Sec. 1681. From the funds appropriated in part 1 for home- and community-based services, the department and local waiver agents shall encourage the use of family members, friends, and neighbors of home- and community-based services participants, where appropriate, to provide homemaker services, meal preparation, transportation, chore services, and other nonmedical covered services to participants in the Medicaid home- and community-based services program. This section shall not be construed as allowing for the payment of family members, friends, or neighbors for these services unless explicitly provided for in federal or state law.

Sec. 1682. (I) The department shall implement enforcement actions as specified in the nursing facility enforcement provisions of section 1919 of title **XIX,** 42 USC 1396r.

(2) The department is authorized to receive and spend penalty money received as the result of noncompliance with medical services certification regulations. Penalty money, characterized as private funds, received by the department shall increase authorizations and allotments in the long-term care accounts.

(3) Any unexpended penalty money, at the end of the year, shall carry fonvard to the following year.

Sec. 1683. The department shall promote activities that preserve the dignity and rights ofterminally ill and chronically ill individuals. Priority shall be given to programs, such as hospice, that focus on individual dignity and quality of care provided persons with terminal illness and programs serving persons with chronic illnesses that reduce the rate of suicide through the advancement of the knowledge and use of improved, appropriate pain management for these persons; and initiatives that train health care practitioners and faculty in managing pain, providing palliative care, and suicide prevention.

Sec. 1684. (1) Of the funds appropriated in part 1 for the Medicaid home- and community-based services waiver program, the payment rate allocated for administrative expenses for fiscal year 2006-2007 shall continue at the rate implemented in fiscal year 2005-2006 afler the $2.00 per person per day mandated reduction.

(2) The savings realized from continuing the reduced administrative rate shall be reallocated to increase enrollment in the waiver program and to provide direct services to eligible program participants.

(3) The department shall provide a report by April 1, 2007, to the house ofrepresentatives and senate appropriations subcommittees on community health and the house and senate fiscal agencies on the number of nursing home patients discharged who are subsequently enrolled in the Medicaid home- and community-based services waiver program, and the associated cost savings.

Sec. 1685. All nursing home rates, class I and class III, must have their respective fiscal year rate set 30 days prior to the beginning of their rate year. Rates may take into account the most recent cost report prepared and certified by the preparer, provider corporate owner or representative as being true and accurate, and filed timely, within **5** months of the fiscal year end in accordance with Medicaid policy. If the audited version of the last report is available, it shall be used. Any rate factors based on the filed cost report may be retroactively adjusted upon completion of the audit of that cost report.

Sec. **1686.** (1) The department shall submit a report by April **30,2007** to the house of representatives and senate appropriations subcommittees on community health and the house and senate fiscal agencies on the progress of **4** Medicaid long-term care single point of entry services pilot projects. The department shall also submit a final plan to the house of representatives and senate subcommittees on community health and the house and senate fiscal agencies **60** days prior to any expansion of the program.

(2) In addition to the report required under subsection (I), the department shall report all of the following to the house of representatives and senate appropriations subcommittees on community health and the house of representatives and senate fiscal agencies by September 30,2007:

(a) The total cost of the single point of entry program

(b) The total cost of each designated single point of entry

(c) The total amount of Medicaid dollars saved because of the program

(d) The total number of emergent single point of entry cases handled and the average length of time for placement in long-term care for those cases.

(e) The total number of single point of entry cases involving transfer from hospital settings to long-term care settings and the average length of time for placement of those cases in long-term care settings.

(3) It is the intent of the legislature that funding for single point of entry for long-term care end on September 30, 2008.

(4) **As** used in this section, "single point of entry" means a system that enables consumers to access Medicaid long-termcare services and supports through 1 agency or organization and that promotes consumer education and choice of long-term care options.

Sec. **1687.** (1) From the funds appropriated in part 1 for long-term care services, the department shall contract with a stand-alone psychiatric facility that provides at least 20% of its total care to Medicaid recipients to provide access to Medicaid recipients who require specialized Alzheimer's disease or dementia care.

(2) The department shall report to the senate and house appropriations subcommittees on community health and the senate and house fiscal agencies on the effectiveness of the contract required under subsection (1) to improve the quality of services to Medicaid recipients.

Sec. **1688.** The department shall not impose a limit on per unit reimbursements to service providers that provide personal care or other services under the Medicaid home- and community-based services waiver program for the elderly and disabled. The department's per day per client reimbursement cap calculated in the aggregate for all services provided under the Medicaid home- and community-based services waiver is not a violation of this section.

Sec. **1689.** (1) Priority in enrolling additional persons in the Medicaid home- and community-based services waiver program shall be given to those who are currently residing in nursing homes or who are eligible to be admitted to a nursing home if they are not provided home- and community-based services. The department shall implement screening and assessment procedures to assure that no additional Medicaid eligible persons are admitted to nursing homes who would be more appropriately served by the Medicaid home- and community-based services waiver program. If there is a net decrease in the number of Medicaid nursing home days *of* care during the most recent quarter in comparison with the previous quarter and a net cost savings attributable to moving individuals from a nursing home to the home- and community-based services waiver program, the department shall transfer the net cost savings to the home- and community-based services waiver program. If a transfer is required, it shall be done on a quarterly basis.

(2) Within 30 days of the end of each fiscal quarter, the department shall provide a report to the senate and house appropriations subcommittees on community health and the senate and house fiscal agencies that details existing and future allocations for the home- and community-based services waiver program by regions as well as the associated expenditures. The report shall include information regarding the net cost savings from moving individuals from a nursing home to the home- and community-based services waiver program and the amount of funds transferred.

Sec. 1691. The funding increase of $31,462,600.00 provided in part 1 for the adult home help program shall be passed through to adult home help workers subject to the following conditions:

(a) All adult home help workers providing care under the adult home help program shall receive a wage of at least $7.00 per hour, effective October 1, 2006.

(b) Adult home help workers employed by a county which paid those adult home help workers at least $7.00 per hour as of July 1, 2006 shall receive a wage rate increase of $0.50 per hour.

(c) The department, in conjunction with the department of human services, shall revise any policies, rules, procedures, or regulations that may be an administrative barrier to the implementation of the wage increases described in this section.

Sec. 1692. (1) The department of community health is authorized to pursue reimbursement for eligible services provided in Michigan schools from the federal Medicaid program. The department and the state budget director are authorized to negotiate and enter into agreements, together with the department of education, with local and intermediate school districts regarding the sharing of federal Medicaid services funds received for these services. The department is authorized to receive and disburse funds to participating school districts pursuant to such agreements and state and federal law.

(2) From the funds appropriated in part 1 for medical services school services payments, the department is authorized to do all of the following:

(a) Finance activities within the medical services administration related to this project.

(b) Reimburse participating school districts pursuant to the fund-sharing ratios negotiated in the state-local agreements authorized in subsection (1).

(c) Offset general fund costs associated with the medical services program.

Sec. 1693. The special Medicaid reimbursement appropriation in part 1 may be increased if the department submits a medical services state plan amendment pertaining to this line item at a level higher than the appropriation. The department is authorized to appropriately adjust financing sources in accordance with the increased appropriation.

Sec. 1694. The department of community health shall distribute $695,000.00 to children's hospitals that have a high indigent care volume, The amount to be distributed to any given hospital shall be based on a formula determined by the department of community health.

Sec. 1697. (1) As may be allowed by federal law or regulation, the department may use funds provided by a local or intermediate school district, which have been obtained from a qualifying health system, as the state match required for receiving federal Medicaid or children health insurance program funds. Any such funds received shall be used only to support new school-based or school-linked health services.

(2) A qualifying health system **is** defined as any health care entity licensed to provide health care services in the state of Michigan, that has entered into a contractual relationship with a local or intermediate school district to provide or manage school-based or school-linked health services.

Sec. 1699. The department may make separate payments directly to qualifying hospitals serving a disproportionate share of indigent patients in the amount of $50,000,000.00, and to hospitals providing graduate medical education training programs. If direct payment for GME and DSH is made to qualifying hospitals for services to Medicaid clients, hospitals will not include GME costs or DSH payments in their contracts with HMOs.

Sec. 1701. The department shall make available to Medicaid providers and HMOs an online resource that will list enrollment and benefits information for each Medicaid recipient. This resource shall be made available to providers and HMOs at no charge.

Sec. 1710. Any proposed changes by the department to the MIChoice home- and community-based services waiver program screening process shall he provided to the members of the house and senate appropriations subcommittees on community health prior to implementation of the proposed changes.

Sec. 1711. (1) The department shall maintain the 2-tier reimbursement methodology for Medicaid emergency physicians professional services that was in effect on September 30,2002, subject to the following conditions:

(a) Payments by case and in the aggregate shall not exceed 70% of Medicare payment rates

(b) Total expenditures for these services shall not exceed the level of total payments made during fiscal year 2001 2002, after adjusting for Medicare copayments and deductihles and for changes in utilization.

(2) To ensure that total expenditures stay within the spending constraints of subsection (1)(b), the department shall develop a utilization adjustor for the basic 2-tier payment methodology. The adjustor shall be based on a good faith estimate by the department as to what the expected utilization of emergency room services will be during fiscal year 2006-2007, given changes in the number and category of Medicaid recipients. If expenditure and utilization data indicate that the amount and/or type of emergency physician professional services are exceeding the department's estimate, the utilization adjustor shall be applied to the 2-tier reimbursement methodology in such a manner as to reduce aggregate expenditures to the fiscal year 2001-2002 adjusted expenditure target.

(3) The department shall encourage each Medicaid HMO to create a criteria-based emergency room observation rate for Medicaid eligibles with a length of stay of not more than 24 hours.

Sec. 1712. (1) Subject to the availability offunds, the department shall implement a rural health initiative. Available funds shall first be allocated as an outpatient adjustor payment to be paid directly to hospitals in rural counties in proportion to each hospital's Medicaid and indigent patient population. Additional funds, if available, shall be allocated for defibrillator grants, EMT training and support, or other similar programs.

(2) Except as otherwise specified in this section, "rural" means a county, city, village, or township with a population of not more than 30,000, including those entities if located within a metropolitan statistical area.

Sec. 1713. (1) The department, in conjunction with the Michigan dental association, shall undertake a study to determine the level of participation by Michigan licensed dentists in the state's Medicaid program. The study shall identify the distribution of dentists throughout the state, the volume of Medicaid recipients served by each participating dentist, and areas in the state underserved for dental services.

(2) The study described in subsection (1) shall also include an assessment of what factors may be related to the apparent low participation by dentists in the Medicaid program, and the study shall make recommendations as to how these barriers to participation may be reduced or eliminated.

(3) This study shall be provided to the senate and house appropriations subcommittees on community health and the senate and house fiscal agencies no later than April 1,2007.

Sec. 1716. The department shall seek to maintain a constant enrollment level within the Medicaid adult benefits waiver program throughout fiscal year 2006-2007.

Sec. 1717. (1) The department shall create 2 pools for distribution ofdisproportionate share hospital funding. The first pool, totaling $45,000,000.00, shall be distributed using the distribution methodology used in fiscal year 2003-2004. The second pool, totaling $5,000,000.00, shall be distributed to unaffiliated hospitals and hospital systems that received less than $900,000.00 in disproportionate share hospital payments in fiscal year 2003-2004 based on a formula that is weighted proportional to the product of each eligible system's Medicaid revenue and each eligible system's Medicaid utilization.

(2) By September 30,2007, the department shall report to the senate and house appropriations subcommittees on community health and the senate and house fiscal agencies on the new distribution of funding to each eligible hospital from the 2 pools.

Sec. 1718. The department shall provide each Medicaid adult home help beneficiary or applicant with the right to a fair hearing when the department or its agent reduces, suspends, terminates, or denies adult home help services. If the department takes action to reduce, suspend, terminate, or deny adult home help services, it shall provide the beneficiary or applicant with a written notice that states what action the department proposes to take, the reasons for the intended action, the specific regulations that support the action, and an explanation of the beneficiary's or applicant's right to an evidentiary hearing and the circumstances under which those services will be continued if a hearing is requested.

Sec. 1720. The department shall continue its Medicare recovery program

Sec. 1721. The department shall conduct a review of Medicaid eligibility pertaining to funds prepaid to a nursing home or other health care facility that are subsequently returned to an individual who becomes Medicaid eligible and shall report its findings to the members of the house and senate appropriations subcommittees on community health and the house and senate fiscal agencies not later than May 15,2007. Included in its report shall be recommendations for policy and procedure changes regarding whether any funds prepaid to a nursing home or other health care facility that are subsequently returned to an individual, after the date of Medicaid eligibility and patient pay amount determination, shall be considered as a countable asset and recommendations for a mechanism for departmental monitoring of those funds.

Sec. 1722. (1) From the funds appropriated in part I for special Medicaid reimbursement payments, the department is authorized to make a disproportionate share payment of $33,167,700.00 for health services provided by Hutzel Hospital.

(2) The funding authorized under subsection (1) shall only be expended if the necessary Medicaid matching funds are provided by, or on behalf of, the hospital as allowable state match.

Sec. 1724. The department shall allow licensed pharmacies to purchase injectable drugs for the treatment of respiratory syncytial virus for shipment to physicians' offices to be administered to specific patients. **If** the affected patients are Medicaid eligible, the department shall reimburse pharmacies for the dispensing of the injectable drugs and reimburse physicians for the administration of the injectable drugs.

Sec. 1725. The department shall continue to work with the department of human services to reduce Medicaid eligibility errors related to basic eligibility requirements and income requirements.

Sec. 1726. Any clinical laboratory performing a creatinine test on a Medicaid client shall report the glomerular filtration rate (eGFR) of the patient and shall report it as a percent of kidney function remaining,

Sec. 1728. The department shall make available to qualifying Medicaid recipients, not based on Medicare guidelines, freestanding, electric, lifting, and transferring devices.

Sec. 1731. (1) Subject to subsection (2), the department shall continue an asset test to determine Medicaid eligibility for individuals who are parents, caretaker relatives, or individuals between the ages of 18 and 2 I and who are not required to be covered under federal Medicaid requirements.

(2) Regardless of the results of the asset test established under subsection (1), an individual who is between the ages of 18 and 21 and is not required to be covered under the federal Medicaid requirements is not eligible for the state Medicaid program if his or her parent, parents, or legal guardian has health care coverage for him or her or has access to health care coverage for him or her.

Sec. 1732. The department shall assure that, if proposed modifications to the quality assurance assessment program for nursing homes are not implemented, the projected general fund/general purpose savings shall not be achieved through reductions in nursing home reimbursement rates.

Sec. 1733. The department shall seek additional federal funds to permit the state to provide financial support for electronic prescribing and other health information technology initiatives.

Sec. 1734. The department shall seek federal funds that will permit the state to provide financial incentives for positive health behavior practiced by Medicaid recipients. The structure of this incentive program may be similar to programs in other states that authorize monetary rewards to be deposited in individual accounts for Medicaid recipients who demonstrate positive changes in health behavior.

Sec. 1735. (1) The department shall establish a committee that will attempt to identify possible Medicaid program savings associated with the creation of a preferred provider program or an alternative program for durable medical equipment, prosthetics, and orthotics.

(2) To assure quality and access, the preferred provider program shall involve providers who can offer a broad statewide network of services and who are accredited by the joint commission on accreditation of health care organizations or the accreditation commission for health care, inc. and the American board for certification in orthotics and prosthetics.

(3) This committee shall include, at minimum, representatives from each of the contracted Medicaid HMOs, the medical services administration, the Michigan state medical society, the Michigan osteopathic society, the Michigan home health association, the Michigan health and hospital association, and 2 accredited providers.

(4) By April I, 2007, the committee shall report to the senate and house of representatives subcommittees on community health, the state budget director, and the department on possible durable medical equipment contracting opportunities and anticipated Medicaid program savings

Sec. 1738. (1) The department shall explore ways to increase the federal disproportionate share hospital cap.

(2) If the disproportionate share hospital cap is increased, the department shall consider increasing funding for county health plans and shall consider disproportionate share hospital payments to trauma centers.

Sec. 1739. The department shall determine the 10 most prevalent and costly ailments affecting Medicaid recipients and shall establish medical outcome targets for each of those ailments. The department may use indicators that

recipients are successfully managing chronic disease, measures of recipient compliance with treatment plans, and studies of the proportion of Medicaid providers who follow established best practices in treating chronic disease as possible medical outcome measures. The department shall make bonus payments available to Medicaid HMOs that meet these outcome targets.

Sec. 1740. From the funds appropriated in part 1 for health plan services, the department shall assure that all GME funds are promptly distributed to qualifying hospitals using a methodology developed in consultation with the graduate medical education advisory group. The advisory group shall include representatives of the Michigan health and hospital association and Michigan association of health plans. If the department and the advisory group are unable to reach a consensus on the distribution methodology, the department shall initiate a legislative transfer to transfer the GME funds from health plan services to hospital services and therapy and distribute the GME funds using the mechanism in place for fiscal year 2005-2006.

Sec. 1741. The department shall continue to provide nursing homes the opportunity to receive interim payments upon their request. The department shall make efforts to ensure that the interim payments are as similar to expected cost-settled payments as possible.

Sec. 1742. The department shall allow the retention of $1,000,000.00 in special Medicaid reimbursement funding by any public hospital that meets each of the following criteria:

(a) The hospital participates in the intergovernmental transfers.

(b) The hospital is not affiliated with a university.

(c) The hospital provides surgical services

(d) The hospital has at least 10,000 Medicaid bed days

Sec. 1746. Beginning October I, 2006, the department shall increase the monthly Medicaid personal care supplement by $10.00 to adult foster care facilities and homes for the aged providing personal care services to Medicaid beneficiaries.

Sec. 1747. In order to be reimbursed for adult home help services provided to Medicaid recipients, the matching of adult home help providers with service recipients shall be coordinated by the local county department of human services.

Sec. 1749. Effective September 30, 2007, the department shall require all Medicaid health plans to use the same standard billing formats.

Sec. 1751. The department shall provide a report by April I, 2007, to the house of representatives and senate appropriations subcommittees on community health and the house and senate fiscal agencies on establishing Medicaid diagnosis related group rates based on fee-for-service and health plan costs.

Sec. 1752. The department shall provide a Medicaid health plan with any information that may assist the Medicaid health plan in determining whether another party may be responsible, in whole or in part, for the payment of health benefits.

Sec. 1753. The department shall take steps to obtain data from auto insurers on insurance payouts for health care claims, If the auto insurers do not voluntarily release the information upon request, the department shall propose legislation to require those insurers to disclose that information upon request. The department shall provide the information received under this section to Medicaid health plans.

Sec. 1756. Not later than March 1,2007, the department shall establish and implement a specialized case management program to serve the most costly Medicaid beneficiaries who are not enrolled in a health plan and are noncompliant with medical management, including persons with chronic diseases and mental health diagnoses, high prescription drug utilizers, members demonstrating noncompliance with previous medical management, and neonates. The case management program shall, at a minimum, provide a performance payment incentive for physicians who manage the recipient's care and health costs in the most effective way. The department may also develop additional contractual arrangements with 1 or more Medicaid HMOs for the provision of specialized case management services. Contracts with Medicaid HMOs may include provisions requiring collection of data related to Medicaid recipient compliance. Measures of patient compliance may include the proportion of clients who fill their prescriptions, the rate of clients who do not show for scheduled medical appointments, and the proportion of clients who use their medication.

Sec. 1757. The department shall direct the department of human services to obtain proof from all Medicaid recipients that they are legal United States citizens or otherwise legally residing in this country before approving Medicaid eligibility.

Sec. 1758. The department shall submit a report on the number of individuals who receive the emergency services only Medicaid benefit and the annual amount of Medicaid expenditures for this population to the house of representatives and senate appropriations subcommittees on community health and the house and senate fiscal agencies by April 1, 2007.

Sec. 1759. The department shall implement the following policy changes included in the federal deficit reduction act of 2005, Public Law 109-171:

(a) Lengthening the look back policy for asset transfers from 3 to **5** years.

(b) Changing the penalty period to begin the day an individual applies for Medicaid.

(c) Individuals with more than $500,000.00 in home equity do not qualify for Medicaid.

(d) Utilize the Medicaid false claim act, 1977 **PA** 72, MCL 400.601 to 400.613, to collect an enhanced state share of damages collected from entities that have been successfully prosecuted for filing a fraudulent Medicaid claim.

Sec. 1760. (1) In addition to the funds appropriated in part 1 for the health information technology initiatives, the department shall seek out and apply for federal and private grant funding for health information technology efforts.

(2) The department shall apply for Medicaid transformation grant funds made available in the federal deficit reduction act of 2005, Public Law 109-171, to support health information technology efforts.

Sec. 1761. (1) The department shall distribute all funds recovered by the medical services administration from prior and future Medicaid access to care initiative payments exceeding the hospital upper payment limit for inpatient and outpatient services to hospitals meeting any of the following characteristics:

(a) Is located in a rural county as determined by the most recent United States census or is located in a city, village, or township with a population of not more than 12,000 and in a county with a population of not more than 1 10,000 as of the official federal 2000 decennial census.

(b) Is a Medicare sole community hospital.

(c) **Is** a Medicare dependent hospital and rural referral center hospital

(2) The distribution under subsection (1) shall be based upon each hospital's Medicaid fee-for-service and HMO payments as developed in consultation with rural hospitals and the Michigan health and hospital association.

Sec. 1762. In order to save money, the department shall adopt an Internet-based workflow management tool *to* streamline administrative functions such as prior authorizations, provider correspondence, provider enrollment, third-party recovery, level of care determinations, claims processing, and provider, interdepartmental, and contractor communication.

Sec. 1763. From the funds appropriated in part 1 for health information technology initiatives, the department shall participate in a pilot project related to the electronic exchange of health information in southeast Michigan and make these funds available through a competitive bid process.

Sec. 1764. The department will annually certify rates paid to Medicaid health plans as being actuarially sound in accordance with federal requirements and will provide a copy of the rate certification and approval immediately to the house of representatives and senate appropriations subcommittees on community health and the house and senate fiscal agencies.

Sec. 1767. The department shall study and evaluate the impact of the change in the way in which the Medicaid program pays pharmacists for prescriptions from average wholesale price to average manufacturer price as required by the federal deficit reduction act of 2005, Public Law 109-171. By March 1, 2007, the department shall submit a report of its study to the senate and house of representatives appropriations subcommittees on community health and the senate and house fiscal agencies. If the department finds that there is a negative impact on the pharmacists, the department shall reexamine *the* current pharmaceutical dispensing *fee* structure established under section 1620 and include in the report recommendations and proposals to counter the negative impact of that federal legislation.

This act is ordered to take immediate effect.

Secretary of the Senate

Clerk of the House of Representatives

Approved

Governor

COMMUNITY HEALTH
EXECUTIVE BUDGET BILL

A bill to make appropriations for the department of community health and certain state purposes related to mental health, public health, and medical services for the fiscal year ending September 30, 2008; to provide for the expenditure of those appropriations; to create funds; to require and provide for reports; to prescribe the powers and duties of certain local and state agencies and departments; and to provide for disposition of fees and other income received by the various state agencies.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

PART 1

LINE-ITEM APPROPRIATIONS

Sec. 101. Subject to the conditions set forth in this bill, the amounts listed in this part are appropriated for the department of community health for the fiscal year ending September 30,2008, from the funds indicated in this part. The following is a summary of the appropriations in this part:

DEPARTMENT OF COMMUNITY HEALTH

APPROPRIATION SUMMARY:

Full-time equated unclassified positions.....6.0
Full-time equated classified positions.....4,655.2
Average population 1,109.0
GROSS APPROPRIATION ..... $ 11,538,938,600
Interdepartmental grant revenues:

Total interdepartmental grants and intradepartmental transfers 38.850.900
ADJUSTED GROSS APPROPRIATION ..... $ 1 1,500,087,700
Federal revenues:
Total federal revenues 6,440,613,100
Special revenue funds:
Total local revenues 246,671,500
Total private revenue 64,702,**800**
Merit award trust fund 161,900,000
Total other state restricted revenues 1,587,709,600
State general *fund/general* purpose $2,998,490,700
Sec. 102. DEPARTMENTWIDE ADMINISTRATION
Full-time equated unclassified positions 6.0
Full-time equated classified positions 226.5
Director and other unclassified--6.0 FTE positions.... $ 581,500
Community health advisory council 7,000
Departmental administration and management--198.0
FTE positions 23,881,600
Office of long term care supports and services--18.5
FTE positions 2,713,800
Worker's compensation program 9,706,000
Human resources optimization user charges 285,500
Rent and building occupancy 10,043,300
Developmental disabilities council and
projects--10.0 FTE positions 2,772,200

GROSS APPROPRIATION ..... $ 49,999,00, 0
Appropriated from:
Federal revenues:
Total federal revenues 14,083,900
Special revenue funds:
Total private revenues 76,000
Total other state restricted revenues 3,500,900
State general fund/general purpose ..... $ 32,133,00, 0

Sec. 103. MENTAL HEALTH/SUBSTANCE ABUSE SERVICES ADMINISTRATION AND SPECIAL PROJECTS

Full-time equated classified positions 111.0
Mental health/substance abuse program administration--110.0 FTE positions ..... $ 13,520,9, 0
Consumer involvement program 189,100
Gambling addiction-- 1.0 FTE position 3,500,000
Protection and advocacy services support 777,400
Mental health initiatives for older persons 1,291,200
Community residential and support services 2,713,000
Highway safety projects 400,000
Federal and other special projects 3,277,200
Family support subsidy 19,036,000
Housing and support services 9.306.800
GROSS APPROPRIATION ..... $ 53,270,0, 0
Appropriated from:
Federal revenues:

Total federal revenues 35,077,400
Special revenue funds:
Total private revenues 190,000
Total other state restricted revenues 3,500,000
State general fund/general purpose ..... $ 148,932,0 0

Sec. 104. COMMUNITY MENTAL HEALTWSUBSTANCE ABUSE SERVICES PROGRAMS

Full-time equated classified positions 9.5
Medicaid mental health services ..... $ 1,878,870,4 0
Community mental health non-Medicaid services 319,566,100
Medicaid adult benefits waiver 40,000,000
Multicultural services 5,163.800
Medicaid substance abuse services 36,285,300
Respite services 1,000,000
CMHSP, purchase of state services contracts 136,239,300
Civil service charges 1,499,300
Federal mental health block grant--2.5 FTE positions .. 15,367,900
State disability assistance program substance abuse services 2,509,800
Community substance abuse prevention, education and treatment programs 85,268,000
Children's waiver home care program 19,549,800
Omnibus reconciliation act implementation--7.0 FTE positions 12,367,200
Children with serious emotional disturbance waiver 570.000

GROSS APPROPRIATION ..... $ 2,554,260,0 0
Appropriated from:
Federal revenues:
Total federal revenues 1,244,524,700
Special revenue funds:
Total local revenues 26,072,100
Total other state restricted revenues 107,365,500
State general fund/general purpose ..... $ 1,176,298,8 0

Sec. 105. STATE PSYCHIATRIC HOSPITALS, CENTERS FOR PERSONS WITH DEVELOPMENTAL DISABILITIES, AND FORENSIC AND PRISON MENTAL HEALTH SERVICES

Total average population 1,109.0
Full-time equated classified positions 2,867.3
Caro regional mental health center - psychiatric hospital – adult--481.3 FTE positions ..... $ 43,646,6 0
Average population 179.0
Kalamazoo psychiatric hospital – adult--466.6 FTE positions 43,120,900
Average population 186.0
Walter **P**. Reuther psychiatric hospital - Adult--437.3 FTE positions 43,147,800
Average population 236.0
Hawthorn center - psychiatric hospital - children and adolescents--218.0 FTE positions 21,497,600
Average population 74.0

Mount Pleasant center -developmental
Disabilities--472.7 FTE positions.....46.936.300
Average population 209.0
Center for forensic psychiatry--475.0 FTE positions ... 51.582.200
Average population 225.0
Forensic mental health services provided to the
department of corrections.. 316.4 FTE positions 37,548,900
Revenue recapture 750,000
IDEA, federal special education 120,000
Special maintenance and equipment 335,300
Purchase of medical services for residents of
hospitals and centers 2,045,600
Severance pay 216,900
Gifts and bequests for patient living and treatment
environment 1,000.000
GROSS APPROPRIATION ..... $ 291,768,0 0
Appropriated from:
Interdepartmental grant revenues:
Interdepartmental grant from the department of
corrections 37,548,900
Federal revenues:
Total federal revenues 39,520,900
Special revenue funds:
CMHSP, purchase of state services contracts..... 136,239,300
Other local revenues 16.533,500

Total private revenues..... 1,000,000
Total other state restricted revenues..... 10,876,700
State general fund/general purpose ..... $ 50,048,800

Sec. 106. PUBLIC HEALTH ADMINISTRATION

Full-time equated classified positions.....86.4
Public health administration--11.0 FTE positions..... $ 1,858,100
Minority health grants and contracts--3.0 FTE positions 1,491,000
Vital records and health statistics--72.4 FTE positions..... 7,947,900
GROSS APPROPRIATION ..... $ 11,297,000
Appropriated from:
Interdepartmental grant revenues:
Interdepartmental grant from the department of human services..... 745,300
Federal revenues:
Total federal revenues 3,012,100
Special revenue funds:
Total other state restricted revenues..... 5,988,100
State general fund/general purpose ..... $ 1,551,500

Sec. 107. HEALTH POLICY, REGULATION, AND PROFESSIONS

Full-time equated classified positions.....418.6
Health systems administration--194.6 FTE positions.... $ 22,514,800
Emergency medical services program state staff--8.5

FTF positions..... 1,471,900
Radiological health administration--21.4 FTE positions 2,671,600
Emergency medical services grants and services—7.0
FTF positions..... 488,700
Health professions—137.0 FTE positions..... 17,950,600
Background check program 4,474,400
Health policy, regulation, and professions
administration--30.7 FTE positions.....5,538,300
Nurse scholarship, education, and research
program--3.0 FTE positions 988,700
Certificate of need program administration--14.0 FTE
positions 1,769,300
Rural health services--I.0 FTE position..... 1,403,800
Michigan essential health provider..... 1,847,100
Primary care services—1.4 FTE positions..... 2,022,700
GROSS APPROPRIATION..... $ 63,141,900
Appropriated from:
Interdepartmental grant revenues:
Interdepartmental grant from the department of
treasury, Michigan state hospital finance authority. 1 16,300
Federal revenues:
Total federal revenues 23,742,100
Special revenue funds:
Total local revenues..... 227,700
Total private revenues..... 350,000